STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM

DEMOGRAPHIC DATA – All Facilities

FACILITY INFORMATION:

Type of Facility: ☐ Chronic Disease Hospital ☐ General Hospital/Children's Hospital	☐ Hospital for Mentally Ill Persons ☐ Hospital for the Care of Hospice Patients ☐ Maternity Hospital ☐ Outpatient Surgical Facility
Facility Name and Address:	License Number: Sequential Report Number:
Reporter's Name:	
Contact Person: Name: Telephone Number:	

PATIENT INFORMATION:

Medical Record Number:	Age	Date of Admission:
Patient's Billing Number:	Sex ☐M ☐F	Date and Time of Event: Date: Time:
		Date and Time Event First Known: Date: Time:
Date of Patient Death (if applicable):		
Admission Diagnosis:		

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Form AE #1
2/11/2010

DEPARTMENT OF PUBLIC HEALTH
ADVERSE EVENT REPORTING FORM
HOSPITALS & OUTPATIENT SURGICAL FACILITIES

Sequential Report Number

_____

DEMOGRAPHICS – Hospitals Only

☐ Inpatient ☐ Hospital Based ☐ Off Campus Satellite Site Name:_____ Address_____	☐ Outpatient ☐ Hospital Based ☐ Off Campus Satellite Site Name:_____ Address_____
LOCATION OF OCCURENCE: ☐ Medical Intensive Care ☐ Neonatal Intensive Care ☐ Surgical Intensive Care Unit ☐ Adult Medical ☐ Adult Surgical ☐ Ambulatory Surgical ☐ Cardiac Cath Lab ☐ Cardiac Care ☐ Dialysis ☐ Emergency Department	☐ Obstetrical /Gynecological ☐ Operating Room ☐ Outpatient Services - Specify Type _____ ☐ Pediatrics ☐ Psychiatric ☐ Diagnostic Services – Specify Type: _____ ☐ Rehabilitative Services – Specify Type: _____ ☐ Other_____

NOTIFICATIONS:

PATIENT AND/OR AUTHORIZED REPRESENTATIVE NOTIFIED OF EVENT: Y☐ Date notified _____ N ☐

DID THE PATIENT EXPIRE? Y ☐ N ☐
If yes:

MEDICAL EXAMINER NOTIFIED Y ☐ N ☐ CASE NUMBER (if applicable)	AUTOPSY PERFORMED (if applicable) Y ☐ N ☐ Unknown ☐ LOCATION:

At the time of this report, were any other entities known to have been notified of this event?

Check all that apply: ☐ Centers for Medicare/Medicaid Services ☐ Department of Children and Families ☐ Food and Drug Administration ☐ Joint Commission on the Accreditation of Health Care Organizations	☐ Local/State Police ☐ Office of Protection and Advocacy for Persons with Disabilities ☐ State Fire Marshal ☐ Department of Social Services, Protective Services ☐ Unknown to reporter at time of report

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_____

"CUT & PASTE" DESCRIPTION OF EVENT HERE FROM LIST

Facts of Event and Status of Patient Condition:

Immediate Plan of Action:

FOR DPH USE ONLY

Date Report Received- Emergent	
Date Report Received	
Date Corrective Action Plan Received	

DEPARTMENT OF PUBLIC HEALTH
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CORRECTIVE ACTION PLAN (CAP)

Facility:	Sequential Report Number for which this plan is being submitted:
Patient Billing Number:	Date CAP Submitted:
Event being addressed:	
Findings:	
Corrective Action Plan to prevent reoccurrence: Does JCAHO require a root cause analysis for this event? Y ☐ N ☐	
Time line for implementation:	Completion date for CAP:
Identification of staff member, by title, who has been designated the responsibility for monitoring CAP implementation:	
Submitted by:	Date: